# United Diagnostics
## *VIDEO AMBULATORY EEG*
## *EXPRESS ORDER FORM*
# *Fax: 1.888.539.3001*

☐ ***Melrose, MA*** ☐ ***Quincy, MA*** ☐ ***Providence, RI*** ☐ ***At home setup***

*Patient Name* _____

*Patient Address* _____

_____

*Cell Phone* _____

*Home Phone* _____

*E-mail* _____

☐ *Male* ☐ *Female* *DOB* _____ / _____ / _____

*Insurance* _____ *ID #* _____

***PLEASE PROVIDE US WITH A COPY OF THE FRONT & BACK OF INSURANCE CARD, PATIENT DEMOGRAPHICS,* CLINICAL NOTES & ROUTINE EEG REPORT**

***Reader preference :*** ☐

*Referring Physician* _____

*Address* _____

_____

*Phone #* _____

*Fax #* _____

*NPI #* _____

### *REFERRING PHYSICIAN STATEMENT*

I certify that I am referring the above named patient to United Diagnostics for long term neurophysiological monitoring using the Home Monitoring system. I certify to the best of my knowledge this test and any interpretation is medically necessary in order to diagnose this patient. I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition.

PHYSICIAN SIGNATURE DATE

**We do not currently accept BMC or Neighborhood Insurances**

☐ ***Long Term Ambulatory EEG***

***Length of Monitoring Requested (Check one)***

☐ ***72 hours*** ☐ ***48 hours*** ☐ _____ ***hours***

☐ ***Patient requires special assistance***

☐ ***Video AEEG Study***

***Please send routine EEG and chart notes with your referral***

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***CLINICAL HISTORY Check all that apply***

| | |
|---|---|
| ☐ *General Nonconvulsive Epilepsy* | ***G40.A01*** |
| ☐ *Partial Epilepsy with Impairment* | ***G40.201*** |
| ☐ *Convulsion* | ***R56.9*** |
| ☐ *Syncope* | ***R55*** |
| ☐ *General Convulsive Epilepsy* | ***G40.309*** |
| ☐ *Partial Epilepsy w/o impairment* | ***G40.001*** |
| ☐ *Vertigo* | ***R42*** |
| ☐ *Transient Ischemic Attack* | ***435.30*** |

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***Primary Diagnosis*** _____

***Secondary Diagnosis*** _____

***Etiology*** _____ ***ICD10*** _____

***EEG History***

☐ *REEG* ☐ *SDEEG* ☐ *A-EEG* ☐ *EMU*

***RESULTS***

☐ *Normal* ☐ *Slowing*

☐ *Abnormal Findings* _____

***TEST OBJECTIVE***

☐ *Differential Diagnosis* ☐ *Monitor Interictal*

☐ *Evaluate Epilepsy/Seizure Class*